MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

C9884

932

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Months

Hospital, institution, or street address where death occurred: Long View Nursing Home

How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Warren Allen

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Francenia Brennan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 20, 1862

8. AGE:

Years	Months	Days	If less than one day
85	10	14	hrs. min.

9. Birthplace: Bennettsville S. Carolina (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER

12. Name: Thomas Warren Allen

13. Birthplace: S. Carolina

MOTHER

14. Maiden name: Sally McCallum

15. Birthplace: S. Carolina

16. Informant: Edward D. Allen

Address: Hampstead Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5-47 (month) (day) (year)

Cemetery or crematory: Catholic Cemetery

Location: Columbia S. Carolina

18. Funeral director: J. F. Elmer Sons

Address: Westminster Md.

19. Nov. 3rd 1947 (Date rec'd by registrar) Mrs. W. P. S. Benner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 19 47, at 7 46 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 19 47, to November 3 19 47

and that I last saw h[illegible] alive on November 1 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to Cerebral Sclerotic Coditis	
Due to Vascular disease	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did Injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of Injury — Injured at work?

23. SIGNATURE: Joseph E. Buck MD M. D. or other

Address: Hampstead Md. Date signed: 11-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 09885 76

Reg. Diat. No.

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 yrs.
Hospital, Institution, or street address where death occurred:
266 E. Green
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 266 E. Green
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth M. Bair

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Samuel P. Bair
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6. 1860

8. AGE:

Years	Months	Days	If less than one day
86	11	16	hrs. min.

9. Birthplace (Town, county, and state) Beigleville, Pa.
10. Usual occupation None
11. Industry or business

FATHER
12. Name Henry Claybaugh
13. Birthplace Pa.

MOTHER
14. Maiden name Sarah Cooley
15. Birthplace Pa.

16. Informant Scott S. Bair
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 25. 1947 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18. Funeral director H B Bankard & Son
Address Westminster, Md.

19. 11 24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 1946, to Nov 26 1947 and that I last saw her alive on November 22 1947

	DURATION
Immediate cause of death Coronary occlusion	several hrs
Due to arterio sclerosis & myocardial degeneration	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other
Address Westminster, Md. Date signed 11/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09887

488

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:
County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anna G. Baker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: John L. Baker
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 23 - 1881

8. AGE: Years: 66 Months: 4 Days: 13 If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County, Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER
12. Name: Oliver Engell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hannah Rowe
15. Birthplace: Maryland

16. Informant: John L. Baker
Address: New Windsor, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)
Cemetery or crematory: Church of God Cemetery
Location: Uniontown, Md

18. Funeral director: U. H. Hartley & Sons
Address: Union Bridge & New Windsor Md

19. Nov 6 1947 Ernest Buckey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1947, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947 to Nov 5, 1947
and that I last saw her alive on Nov. 3, 1947

Immediate cause of death: Carcinoma of Uterus
Due to: with Metastasis to other organs
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION: 6 yrs

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: C. Peerslorkers M.D.
M. D. or other
Address: Westminster Date signed 11-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C9886

94a

Reg. Diat. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co
City or town: Taneytown Md. Rt 1 M
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Rural - Taneytown Dist
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 1M -
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Katherine Louise Baldwin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1893 - 10 - 16

8. AGE:

Years	Months	Days	If less than one day
54	1	20	..... hrs. ..... min.

9. Birthplace: Kiser W. Va. (Town, county, and state)
10. Usual occupation: House Keeping
11. Industry or business

FATHER
12. Name: Isaac Baldwin
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Jane Hawhouse
15. Birthplace: W. Va

16. Informant: Mary H. Baldwin
Address: Taneytown Rt 1 Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Nov 29-47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Near Washington D. C.
18. Funeral director: Raymond K. Wright
Address: Union Bridge Md.

19. 11 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 1947 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary artery disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Thorne Deputy Medical Examiner
M. D. or other
Address: Westminster Md Date signed 11/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09888

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 23 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson (If outside city or town limits, write RURAL and give nearest town)

Street No.: York Road (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MYRTLE TAYLOR BAYTOPS

3.(b) Social Security Number: 212-18-2694

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 1, 1906

8. AGE: Years	Months	Days	If less than one day
41	5	5	hrs. min.

9. Birthplace: Cockeysville, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Albert Taylor

FATHER — 13. Birthplace: Baltimore Co., Md.

MOTHER — 14. Maiden name: Florence Johnson

MOTHER — 15. Birthplace: Baltimore Co., Md.

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-10-47 (month) (day) (year)

Cemetery or crematory: Hooks Hill Cem.

Location: Balto. Co.

18. Funeral director: Byron & Mamie Wright

Address: 721 Augusta St. - Balto.

19. 11/6 (Date rec'd by registrar) 19 47 Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6, 19 47, at 5.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14, 19 47 to Nov., 6 19 47 and that I last saw her alive on November 6, th. 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Nelson A. Rucker M. D. M. D. or other

Address: Henryton, Md. Date signed: 11/6/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

09889

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Carroll — Registration Dist. No. 77

Village or City Hampstead — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 20 yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME John Henry Buckley

(a) Residence: No. ____ St., ____ Ward. ____

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	M

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Persis Tracey.

6. DATE OF BIRTH (month, day, and year) Jan 14-1863

7. AGE

Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
84	9	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto Co, (State or country) Maryland

FATHER

13. NAME Daniel R Buckley

14. BIRTHPLACE (city or town) Maryland (State or country)

MOTHER

15. MAIDEN NAME Mary Ann Gouck

16. BIRTHPLACE (city or town) Maryland (State or country)

17. INFORMANT Mrs J. J. Hendley (Address) Reisterstown Md

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place Beckleysville Date Nov 15, 1947

19. UNDERTAKER Edw C Tipton (Address) Hampstead, Md

20. FILED Nov 14, 1947 John S. Hughes Jr Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH November 12 (Month) (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June, 1945, to November 12, 1947

I last saw him alive on Nov 9, 1947; death is said to have occurred on the date stated above, at 9: AM m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Coronary Sclerosis	1947

Other **Contributory Causes** of Importance:

Name of operation ____ Date of ____

What test confirmed diagnosis? Clinical Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? ____

If so, specify ____

(Signed) Maurice C. Pontius M. D.

(Address) Hampstead Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09890

93d

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: 17 Manyslad Md Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, Institution, or street address where death occurred: Old Westminster Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Mary Land County: Baltimore

City or town: Parkton Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Jamie Becker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	divorced

6.(b) Name of husband or wife: Mamie Becker

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): August 4, 1874

8. AGE:

Years	Months	Days	If less than one day
73	3	3	..... hrs. ..... min.

9. Birthplace: Middletown Md (Town, county, and State)

10. Usual occupation: Laborer

11. Industry or business: Genrgly

FATHER — 12. Name: Noah Becker

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Margaret Bull

15. Birthplace: Maryland

16. Informant: Mrs Martin Ed. Schaffer

Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 10, 1947 (month) (day) (year)

Cemetery or crematory: Pine Grove E.U.B.

Location: Parkton, Md.

18. Funeral director: Jacob Hartzler

Address: New Freedom, Pa.

19. Nov 7 1947 (Date rec'd by registrar) Mrs. W. P. L. Demuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 1947, at 11 15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1947, to Nov 7 1947 and that I last saw h.... alive on Nov 5 1947

Immediate cause of death		DURATION
	Chronic Myocarditis	?
Due to	Myocardiac Cardio-Vascular	?
Due to	Coronal	
Other conditions	Cerebral Cerebrovascular	?

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State) —

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Jack E. Buck MD (M. D. or other)

Address: Hampstead Md Date signed: 11-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

09891

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 4 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Rogers Ford
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 113 Dunkirk Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HAZEL ETHELBERT BRITTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Roy D. Britton
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): June 2, 1891

8. AGE: Years	Months	Days	If less than one day
56	5	7	..... hrs. ..... min.

9. Birthplace: Baltimore County, Maryland (Town, county, and state)
10. Usual occupation: Office Worker
11. Industry or business:

FATHER
12. Name: Thomas G. Green
13. Birthplace: Baltimore County, Maryland

MOTHER
14. Maiden name: Martha E. Noonan
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12, 1947 (month) (day) (year)
Cemetery or crematory: Popular Cemetery
Location: Baltimore Co.
18. Funeral director: William Coost Inc.
Address: 1217 St Paul St. Balto Md.
19. Nov. 9 1947 (Date rec'd by registrar) C. Harry Kees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9th 1947 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 5th 1947, to November 9th 1947 and that I last saw h..er alive on November 9th 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	12 days
Due to: Cerebral arteriosclerosis about	5 years
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis about	2 years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Irene Hohman M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 11-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d

BC 09892

Reg. Diat. No.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Hampstead Md RFD #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5207 Norwood Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clarence Randolph Bye

3.(b) Social Security Number 213-03-0903

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Mary Jane Bye

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) November 29 1881

8. AGE: Years 65 | Months 11 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business Manf. Elliott Co-Sporting goods

FATHER 12. Name Frederick Bye

13. Birthplace Germany

MOTHER 14. Maiden name Martha Barnett

15. Birthplace Penna

16. Informant Mary Jane Bye

Address Baltimore Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 11-17-47 (month) (day) (year)

Cemetery or crematory WOODLAWN

Location CITY

18. Funeral director WIEDEFELD & SON

Address GREENMOUNT AVE & 22ND ST.

19. 11 | 18 | 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11 1947 to November 13 1947

and that I last saw h.. alive on November 11 1947

Immediate cause of death Primary Carcinoma Lung. — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph E. Bush M.D. M. D. or other

Address Hampstead Md Date signed 11-18-47

7835

1

12

5/5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09893

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. - 2 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1124 Woodyear Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: NOLA COLEY

3.(b) Social Security Number: 220-14-4220

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Willie Coley
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): October 17, 1916

8. AGE: Years	Months	Days	If less than one day
31	0	28	..... hrs. ..... min.

9. Birthplace: ? ? Georgia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Lewis Oliver
13. Birthplace: Georgia

MOTHER
14. Maiden name: Anna Parker
15. Birthplace: Georgia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 18. 47 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cem.
Location: Edward Ridgely
1463 N Carey St
18. Funeral director: Baltimore Md
Address

19. Nov. 14 1947 (Date rec'd by registrar) Albert R. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 1947 at 5:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12, 1946 to Nov. 14 1947 and that I last saw her alive on November 14, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Hyman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 11-14-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170C

Reg. Dist. No. 09894 82

MV

1. PLACE OF DEATH:
County: Carroll
City or town: Parrsville.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural - Mt. Airy Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Helen Irene Cook

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband ~~or wife~~: Geo. E Cook
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Nov. 23, 1920

8. AGE:

Years	Months	Days	If less than one day
27	0	3	....hrs. ....min.

9. Birthplace: Carroll Co. Maryland.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Horace S. Johnson
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Lucy V. Brown
15. Birthplace: Maryland.

16. Informant: Horace S. Johnson
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof: Nov. 28 1947 (month) (day) (year)
Cemetery ~~or crematory~~: Mt. Zion Cemetery.
Location: near Mt. Airy - Carroll Co. Md.
18. Funeral director: C. W. Waltz
Address: Winfield Md.

19: Nov. 26 1947 (Date rec'd by registrar) Chas D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26 1947 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ....19.... to ....19....
and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Frac. of Cerv. - Lumbar Spine - Crushing injury of Chest, Fe	
Due to fracs. Lower 9 ribs	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 11-26-47
Where did injury occur? Parrsville (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) Route 40.
Means of injury Automobile Injured at work? No.

23. SIGNATURE: James T. Moore Deputy Medical Examiner
M. D. or other
Address: Woodbine Md. Date signed 11/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

09895

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Mon. 19 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: FLORA VIRGINIA CURTIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: James Henry Curtis
6.(c) If alive, give age: 88 years

7. Birth date of deceased (mo., day, yr.): November 23, 1882

8. AGE: Years	Months	Days	If less than one day
65	0	2	...hrs. ...min.

9. Birthplace: Prince George's County, Md.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: Ambrose Philip Carroll
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Rebecca Pinkine
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Brooks Chapel (Burial) 11 28 47
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Brooks
Location: Naylors Md

18. Funeral director: Ritchie Bros
Address: Upper Marlboro Md

19. Nov. 25 19 47 (Date rec'd by registrar) Albert R. Swanborn Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 19 47 at 1:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 19 47, to Nov. 25 19 47
and that I last saw her alive on November 25 19 47

	DURATION
Immediate cause of death: Pulmonary Tuberculosis (12-3-47)	Oct. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben M. Fraas, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 11-25 47

MARYLAND STATE DEPARTMENT OF HEALTH

09896

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Mons., 27 days 3 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-17-
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1618 W. Lanvale Street
(If rural, give LOCATION)

2.(a) If veteran, name war: C

3.(a) FULL NAME: WINNIE BOYD DANIELS

3.(b) Social Security Number: 237-16-2905

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Moses Daniels

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): May 25, 1908

8. AGE: Years	Months	Days	If less than one day
39	6	5	..... hrs. ..... min.

9. Birthplace: Greenville (Pitt) N. Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Lee Boyd
13. Birthplace: N. Carolina

MOTHER
14. Maiden name: Ida Boyd
15. Birthplace: N. Carolina

16. Informant: Deceased
Address

17. Burial, cremation, or removal. Which? Burial Date thereof: Dec 3-1947 (month) (day) (year)

Cemetery or crematory: St Peters Cem

Location: Greenville N C

18. Funeral director: Ealey & Watson

Address: 1000 Beaufort Ave

19. Nov. 30, 1947 (Date rec'd by registrar) Alice R. Frankhauser Local Deputy Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: November 30 1947 at 12:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3, 1947, to Nov. 30, 1947 and that I last saw her alive on November 30, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W Ewan, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 11-30-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09897

938 Bo

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Rural- Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Months

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 8 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. Unk -
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thomas Vincent Dawson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Nellie Mae Dawson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 22 September 1864

8. AGE: Years	Months	Days	If less than one day
83	2	1	hrs. min.

9. Birthplace Texas, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name William Dawson

13. Birthplace Baltimore City, Maryland

MOTHER 14. Maiden name Emma Hubbard

15. Birthplace Baltimore City, Maryland

16. Informant Mrs Ruth Brown

Address 3132 Presstman Street, Baltimore, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Nov 25, 1947 (month) (day) (year)

Cemetery or crematory Parkwood Cem.

Location Balto Md

18. Funeral director William Cook, Inc

Address 1217 E Paul St.

19. Nov 22 1947 (Date rec'd by registrar) C. Harry Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 November 47 19 at 4:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Sept 47 19 to 23 Nov 47 19 and that I last saw him alive on 22 Nov 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	8 Mo
Due to Arteriosclerosis	5 Years
Due to	
Other conditions Psychosis with cerebral arteriosclerosis	5 Years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin Gross, M.D.
Martin Gross M.D.
M. D. or other

Address Springfield State Hospital Date signed 23 Nov 47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09898

136

BC

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 916 Madison Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: JAMES DEMPSEY

3. (b) Social Security Number: 215-12-7119

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Sarah Dempsey
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): August 16, 1923

8. AGE:	Years	Months	Days	If less than one day
	24	3	11	....hrs. ....min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Shipping Clerk
11. Industry or business

FATHER
12. Name: James Dempsey
13. Birthplace: Herfort, North Carolina

MOTHER
14. Maiden name: Lillie Mae Hudson
15. Birthplace: Herfort, North Carolina

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/1/47 (month) (day) (year)
Cemetery or crematory: Arbutus Mem. Pk.
Location: Balto. Co., Maryland
18. Funeral director: William H. Jackson
Address: 616 Penna. Ave., Balto.

19. Nov. 27, 19 47 (Date rec'd by registrar) Albert R. Trumbauer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27, 19 47, at 5:30P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 6, 19 47 to Nov. 27, 19 47 and that I last saw h im alive on Nov. 27, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1939
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Fraser, M.D. M. D. or other
Address: Henryton, Md. Date signed: 11-27-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09899

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 5 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 194 Clay Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: ROSETTA FOOT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Joseph Foot
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): September 15, 1919

8. AGE: Years	Months	Days	If less than one day
28	2	38	..... hrs. ..... min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Robert Green
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Nannie Eveline
15. Birthplace: Annapolis, Md.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/23/47 (month) (day) (year)
Cemetery or crematory: Bayview Hill
Location: West St. Extended

18. Funeral director: Mrs. Charles E. Hinton
Address: 45 Scotland Street Annapolis Md.

19. 11/19 (Date rec'd by registrar) 19 47 Albert R. Brantham Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19, 19 47 at 6.00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 19 47, to Nov. 19, 19 47
and that I last saw her alive on November 19, 19 47

Immediate cause of death	DURATION
Tuberculous enteritis	Jan. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben W. Brown, M.D. M. D. or other
Address: Henryton, Md. Date signed 11/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13B 69900

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Mons. 21 Days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore Co. Md.

City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 Berlin Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: NELLIE ELIZABETH FORD

3. (b) Social Security Number: 213- 26-6703

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: James Albert Ford

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): October 13, 1928

8. AGE: Years	Months	Days	If less than one day
19	1	2	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Lyde
13. Birthplace: S. Carolina

MOTHER
14. Maiden name: Annie Mackey
15. Birthplace: N. Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-20-47 (month) (day) (year)

Cemetery or crematory: Mountcastle Town 11 20 47

Location: Baltimore Md

18. Funeral director: Mrs Katie L Williams

Address: 322 N Dallas Ave

19. Nov. 15 19 47 (Date rec'd by registrar) Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15, 19 47 at 9:A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 19 47, to Nov. 15, 19 47 and that I last saw her alive on November 15, 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1947

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Nathan W Kuman M.D. M. D. or other

Address: Henryton, Md. Date signed: 11-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09901

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Mons. 29 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1026 Leadenhall Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ELIJAH ~~ELI~~ FOSTER

3.(b) Social Security Number 166-10-9235

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1900

8. AGE: Years	Months	Days	If less than one day
47	0	29	hrs. min.

9. Birthplace Chester, S. Carolina
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Allen Foster
13. Birthplace S. Carolina

MOTHER
14. Maiden name Rachel Akin
15. Birthplace S. Carolina

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 18-1947 (month) (day) (year)
Cemetery or crematory Anchorage Cem.
Location Chester, S. C.
18. Funeral director Elroy O. Wilson
Address 1000 Brantley ave

19. Nov. 14 47 (Date rec'd by registrar) Albert A. Smallwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1947 at 8:40A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1947 to Nov. 14 1947 and that I last saw him alive on November 14, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1st 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Swan M. D.
M. D. or other
Address Henryton, Md. Date signed 11-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d

69902

Reg. Dist. No. 80

1. PLACE OF DEATH:
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Uriah S. Fritz

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of ~~husband or~~ wife Mary Waddell Fritz
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 4 - 1891

8. AGE:

Years	Months	Days	If less than one day
56	3	16	..... hrs. ..... min.

9. Birthplace Carroll County, Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name H. Wesley Fritz
13. Birthplace Maryland
MOTHER 14. Maiden name Sarah Lambert
15. Birthplace Maryland
16. Informant Mrs. Mary W. Fritz
Address New Windsor, R. D. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/24/47 (month) (day) (year)
Cemetery or crematory Lutheran Cemetery
Location Uniontown, Md.
18. Funeral director W. H. Hartsler & Sons
Address Union Bridge & New Windsor Md
19. Nov. 22 1947 Emma S. Bunshot
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1947 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1947 to Nov. 20 1947 and that I last saw h.. alive on November 20 1947

Immediate cause of death	DURATION
Carcinoma of the lung	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Marsh M. D.
M. D. or other
Address Westminster Md Date signed 11/20/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09903

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years, 4 months, 25 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 8 years, 4 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore Co

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 504 Virginia Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clara Godwin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: B. Harry Godwin

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): January 15, 1889

8. AGE: Years	Months	Days	If less than one day
58	9	26	..... hrs. ..... min.

9. Birthplace: Towson, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Benjamin F. Bayne

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Phoebe T. Wisner

15. Birthplace: Maryland

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 13 1947 (month) (day) (year)

Cemetery or crematory: Prospect Hill

Location: Towson, Md.

18. Funeral director: William Cook Inc.

Address: 1217 St Paul St. Balto. Md.

19. Nov. 10 19 47 (Date rec'd by registrar) Harry Weil Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10, 19 47 at 1.40 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 19 42, to November 10, 19 47 and that I last saw her alive on November 10, 19 47

Immediate cause of death	DURATION
Cerebral hemorrhage about	5 hours
Due to	
Due to	
Other conditions	
Schizophrenia, paranoid type about	11 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Irene Hehman, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 11-10-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

09904

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days, 7Hrs., 55 Min.

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-2

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1223 E. Lexington St.

(If rural, give LOCATION)

2.(a) If veteran, name war: Yes War 11

3.(a) FULL NAME: CHARLES STERLING GOODMAN

3.(b) Social Security Number: 225-05-5905

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Hattie Goodman

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): April 29, 1915

8. AGE: Years	Months	Days	If less than one day
32	7	1	7 hrs. 25 min.

9. Birthplace: Philadelphia, Pennsylvania (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER — 12. Name: James Goodman

13. Birthplace: Cuba

MOTHER — 14. Maiden name: Maggie Coleman

15. Birthplace: Ohio

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/4/47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Anne Arundell Co.

18. Funeral director: James A. Hayes

Address: 142 W. Hill St.

19. Nov. 30, 1947 (Date rec'd by registrar) Albert R. Swarbrick Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 19 47 at 7:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26 19 47, to Nov. 30 19 47 and that I last saw h... im alive on November 30 19 47

Immediate cause of death	DURATION
Cerebral Accident	2 weeks
Due to	
Due to	
Other conditions: Pulmonary Tuberculosis Feb. 1946	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D. M. D. or other

Address: Henryton, Md. Date signed: 11-30-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

09905

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 6 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 month, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12½ S. Waverly Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

DESSIE DELA GRANGE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Lewis A. DelaGrange, Sr.

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 9/12/1887

8. AGE: Years	Months	Days	If less than one day
60	2	13	hrs. min.

9. Birthplace: Summitt County, Ohio
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Edwin C. Breckenridge

FATHER 13. Birthplace: Akron, Ohio

MOTHER 14. Maiden name: Cynthia Spade

MOTHER 15. Birthplace: Springfield, Ohio

16. Informant: Record, Springfield St. Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 29, 1947 (month) (day) (year)

Cemetery or crematory: Akron

Location: Akron, Ohio

18. Funeral director: Charles L. George

Address: 125 d Liberty St. Cumberland, Md.

19. NOV 25 1947 C. Henry Thaer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/25 1947, at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/9 1947, to 11/25 1947 and that I last saw her alive on 11/24 1947

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to: Hypertensive Cardiovascular Dis.	3 mos.(kn)
Due to: Generalized Arteriosclerosis	3 mos.(KN)
Due to:	
Other conditions: Psychosis with cerebral Arteriosclerosis	3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 11/25/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09906

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo. 25 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 mo. 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore - 5 (If outside city or town limits, write RURAL and give nearest town)

Street No. 2002 E Madison Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HANZLIK, Charles Frederic

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Hanzlik

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Jan. 29, 1881

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	10	1		

9. Birthplace: Czechoslovakia (Town, county, and state)

10. Usual occupation: Retired Painter

11. Industry or business: House Painting

FATHER 12. Name: Fred Hanzlik

13. Birthplace: Czechoslovakia

MOTHER 14. Maiden name: Mary

15. Birthplace:

16. Informant: Springfield State Hospital

Address: Records

17. Burial (Burial, cremation, or removal, which?) Date thereof: 12-3-47 (month) (day) (year)

Cemetery or crematory: Oak Hill

Location: Baltimore Md

18. Funeral director: Frank Cruachanson

Address: 900 W. Chesterfield

19. 12/1 1947 A.W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 1947 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28 1947 to Nov. 30 1947 and that I last saw him alive on November 29 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to: General Arteriosclerosis	unknown
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis (Include pregnancy within 3 months of death)	1½-2 yrs

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Martin Gross M.D. (M. D. or other)

Martin Gross, M.D.

Address: Springfield State Hospital Date signed: Nov. 30 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09907

1310

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4½ months

Hospital, institution, or street address where death occurred: 88 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 88 W. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Jennie Brown Harris

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Harry Grant Harris

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1882

8. AGE: Years	Months	Days	If less than one day
65	9	12	..... hrs. ..... min.

9. Birthplace: Castle Creek Allegheny Co. Pa. (Town, county, and state)

10. Usual occupation: Home-wife

11. Industry or business

FATHER — 12. Name: James H. Hunter

FATHER — 13. Birthplace: Penna

MOTHER — 14. Maiden name: Jennie Carr

MOTHER — 15. Birthplace: Penna.

16. Informant: Mrs. Harry G. Harris

Address: 88 W. Main St. Westminster Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 28/47 (month) (day) (year)

Cemetery or crematory: Union-dale Cemetery

Location: North side Pittsburg Pa.

18. Funeral director: J. S. Myers & Son

Address: Westminster Md.

19. 11/26 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 1947, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1 1947, to Nov 26 1947

and that I last saw her alive on Nov 25 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	10 hrs
Due to: Chronic Myocarditis	1 yr
Due to: Chronic Interstitial Nephritis	20 yrs
Other conditions: Arteriosclerosis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. R Fouty MD (M. D. or other)

Address: Westminster Md. Date signed: 11-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09968

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Mons. 14 Days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1406 Harlem Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SAMUEL TOBOIS HARRIS

3.(b) Social Security Number: 218-03-8636

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Willie Mae Harris
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Aug. 4, 1900

8. AGE: Years	Months	Days	If less than one day
47	3	7	...hrs. ...min.

9. Birthplace: ? ? Maryland (Town, county, and state)
10. Usual occupation: Laundryman
11. Industry or business
FATHER 12. Name: Tobois Harris
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Hester Johnson
MOTHER 15. Birthplace: Maryland
16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-15-47 (month) (day) (year)
Cemetery or crematory Mt. Auburn
Location Baltimore City
18. Funeral director Geo. G. Kelson
Address 1303 Preston an. St.
19. Nov. 11 (Date rec'd by registrar) 19 47 Albert H. Smallwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 19 47, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 19 47 to Nov. 11 19 47 and that I last saw him alive on November 11 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 30 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Nathan Hoffman M. D. M. D. or other
Address Henryton, Md. Date signed 11-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09909

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 17 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 N. Parrish Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DOLORES HORSEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30, 1940

8. AGE: Years	Months	Days	If less than one day
7	3	8	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 11-1947 (month) (day) (year)

Cemetery or crematory: Mt. Calvary,

Location: Brooklyn Via Brooks Ringgold

18. Funeral director:

Address: 1463 N. Carey St

19. 11/7 (Date rec'd by registrar) 1947 Albert R. Lumbaa Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 19 47, at 3.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 19 47, to Nov., 7, 19 47 and that I last saw h er alive on November 7, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md Date signed: 11/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09910

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town) R.D. #1
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn Infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #1 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie A. Howard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: George A. Howard
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 19 1887

8. AGE: Years: 60 Months: 8 Days: 16 If less than one day: hrs. min.

9. Birthplace: Frederick County, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Jackson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Thompson
15. Birthplace: Maryland

16. Informant: Geo. H. Howard
Address: Union Bridge R.D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 6 1947 (month) (day) (year)
Cemetery or crematory: Mt. Olive Cemetery
Location: Frederick County, Md.

18. Funeral director: H. O. Hartzler & Sons
Address: Union Bridge & New Windsor, Md.

19. Nov 5 1947 (Date rec'd by registrar) Registrar

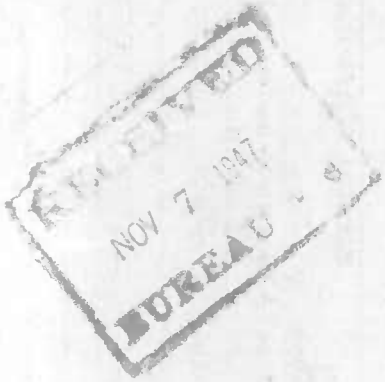
MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3 1947, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 1947, to 1947
and that I last saw h[er] alive on Nov 3 1947
Immediate cause of death: Cerebral Hemorrhage — DURATION
Due to: Cardiac Sclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J H Legg M. D. or other
Address: Union Bridge Date signed: 11-4-47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09311

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 227 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Violetta Eliza Hughes

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Alfred Hughes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 7, 1860

8. AGE: Years	Months	Days	If less than one day
87	5	12	hrs. min.

9. Birthplace: Relay, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Dennis Ring

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Eliza Caples

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Mary Macintyre

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/22/47 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 11/20 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19 19 47 at 4¾ p M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from March 1st 19 47 to Nov. 19th 19 47

and that I last saw h[illegible] alive on Nov. 19th 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	Several years
Due to: Senility	
Due to:	
Other conditions: Edema of lungs	12 hours

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. J. Billingslea M. D. (M. D. or other)

Address: Westminster, Md. Date signed 11-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09912 Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1102 Dorn Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME SYLVIA JOHNSON

3. (b) Social Security Number 214-26-2236

4. Sex: female

5. Color or race: colored

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 29, 1928

8. AGE: Years 19 Months 8 Days 26 If less than one day hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Jessie Johnson

13. Birthplace Virginia

MOTHER 14. Maiden name Nellie Webb

15. Birthplace Maryland

16. Informant Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 28 1947 (month) (day) (year)

Cemetery or crematory Mt Calvary Cem

Location Annapolis Road

18. Funeral director Adolphus Halstead

Address 918 Druid Hill ave

19. 11/24 19 47 (Date rec'd by registrar) Albert R. Swankham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 19 47 at 11.55P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19, 19 47, to Nov. 24, 19 47 and that I last saw her alive on November 24, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis (12-3-47)	June 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter Hoffman M.D. M. D. or other

Address Henryton, Md Date signed 11/24/47

09913

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Mons., 12 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 821 Tessier Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS JONES

3.(b) Social Security Number: 217-22-0487

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Sep.

6.(b) Name of husband or wife: Sophie Jones
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): January 7, 1892

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
55	2	12		

9. Birthplace: Lynchberg Virginia (town, county, and state)
10. Usual occupation: Fish Market
11. Industry or business:

FATHER
12. Name: Louis Jones
13. Birthplace: Unknown

MOTHER
14. Maiden name: Bell Saunder
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: November 23/1947 (month) (day) (year)
Cemetery or crematory: Family cemetery
Location: Martinsville, Montgomery County Va.
18. Funeral director: James T. Allen
Address: 315 Fayette St. Martinsville, Va.
19. Nov. 19, 1947 (Date rec'd by registrar) Albert R. Linthicum Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19, 1947 at 12.01 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7, 1947, to Nov., 19, 1947 and that I last saw him alive on November 19, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Lucas, M. D. M. D. or other
Address: Henryton, Md. Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09314

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 3 months

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 year 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 E. Gittings Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
Charles H. Kleinsmith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 12, 1878

8. AGE: Years	Months	Days	If less than one day
69	4	25	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business:

FATHER
12. Name: Christian Kleinsmith
13. Birthplace: Germany

MOTHER
14. Maiden name: Maggie Batchelor
15. Birthplace: Germany

18. Informant: Mr. August Kleinsmith, brother
Address: 110 E. Gittings Street, Balto. 30

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/8/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem

Location: Reisterstown Highway

18. Funeral director: J. J. Fahey & Sons

Address: 318 Light St.

19. 11/7 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

J.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1947, at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2 1947, to November 5 1947 and that I last saw him alive on November 5 1947

	DURATION
Immediate cause of death: Chronic myocarditis	7 yrs.
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis and alcoholism	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Coronary arterioscler., nephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Martin Gross, M.D.
M. D. or other

Address: Springfield St. Hospital Date signed: 11/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09915

Reg. Dist. No. 14

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -----
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. ~~3829 Wilkens Ave.~~ 2559 W. Fayette St (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: HENRY DANIEL LEMMERMAN

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	white	Widower

6.(b) Name of husband or wife: Anna Lemmerman (MAHR)
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): March 6, 1866

8. AGE: Years	Months	Days	If less than one day
81	7	26	....hrs. ....min.

9. Birthplace: Baltimore, Md
(Town, county, and state)
10. Usual occupation: Fireman
11. Industry or business: Fire department
FATHER 12. Name: John Lemmerman
13. Birthplace: Germany
MOTHER 14. Maiden name: Annie Brody
15. Birthplace: Germany
16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5 '47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: 3801 Frederick Ave
18. Funeral director: Harry H Witzke
Address: 4101 Edmondson Ave.
19. Nov 3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 1 1947 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 16, 1941 to Nov. 1 1947 and that I last saw him alive on Nov. 1 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 yrs.
Due to	
Due to	
Other conditions: Alcoholic Psychosis,	
Alcoholic deterioration	11yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eidlet M.D.
M. D. or other
Address: S. S. H., Sykesville, Md. Date signed: 11. 1. 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

09916

CERTIFICATE OF DEATH

Reg. Diat. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 174 Pennsylvania Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: James M. Massicot

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary A. Chrest

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): August 19, 1870

8. AGE:

Years	Months	Days	If less than one day
77	2	17	...hrs. ...min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER

12. Name: Peter Robert Massicot

13. Birthplace: Maryland

MOTHER

14. Maiden name: Hannah McGreevy

15. Birthplace: Maryland

16. Informant: Mrs. James M. Massicot

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/8/47 (month) (day) (year)

Cemetery or crematory: St. John's Catholic

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 11/6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1947, at 10½a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 17 1947, to Nov. 5 1947 and that I last saw him alive on Nov. 4 - 1947

Immediate cause of death	DURATION
Acute Cardiac Decompensation	24 hrs
Due to: Chronic Interstitial Nephritis	3 yrs
Due to: Arterio Sclerosis	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas R Foutz MD M. D. or Other

Address: Westminster Md Date signed: 11-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 099171

1. PLACE OF DEATH:
County Carroll
City or town Near Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Near Uniontown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bessie D. Mering

3.(b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1871

8. AGE: Years 76 | Months 10 | Days 0 | If less than one day ... hrs. ... min.

9. Birthplace: Carroll Co., Maryland
(Town, county, and state)

10. Usual occupation: Retired school teacher

11. Industry or business

FATHER
12. Name: George T. Mering
13. Birthplace: Maryland

MOTHER
14. Maiden name: Clementine Sweigart
15. Birthplace: Maryland

16. Informant: Ridgely Mering
Address: Baltimore, Maryland.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 11/16/1947
(month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Uniontown, Maryland

18. Funeral director: C.O. Fuss & Son
Address: Taneytown, Maryland.

19. Nov 16 1947
(Date rec'd by registrar)
Margaret P. Engler
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 13 1947, at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 1947 to Nov 13 1947
and that I last saw h... alive on Nov 13 1947

	DURATION
Immediate cause of death	
Due to: Chronic Myocarditis	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: D. N. Legg M. D. or other
Address: Union Bridge Date signed 11-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

STATE OF MARYLAND—CERTIFICATE OF DEATH

69918

94a

1. PLACE OF DEATH

County Carroll Registration Dist. No. 75

Village or City Lineboro No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Elizabeth E. Miller

(a) Residence: No. Lineboro, Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Married

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of Franklin H. Miller

6. DATE OF BIRTH (month, day, and year) Dec. 23 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	10	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housework

9. Industry or business in which work wes done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased lest worked at this occupation (month end year) 1947

11. Total time (years) spent in this occupetion 44

12. BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

FATHER

13. NAME Henry Warner

14. BIRTHPLACE (city or town) (Stete or country) Carroll Co. Md

MOTHER

15. MAIDEN NAME Sydie Miller

16. BIRTHPLACE (city or town) (Stete or country) York Co. Pa.

17. INFORMANT Franklin H. Miller (Address) Lineboro Md

18. BURIAL, CREMATION, OR REMOVAL Piece Stone Church Date 11/7, 1947

19. UNDERTAKER H. E. Leifer (Address) Glen Rock, Pa

20. FILED Nov. 5, 1947 Mrs. H. P. S. Benner Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH November (Month) 4 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from November 3, 1947 to November 4, 1947

I last saw her alive on Nov. 3, 1947; death is said to have occurred on the date stated above, at 6a m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were es follows:

	Date of onset
Coronary Thrombosis	11-3-47

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Maurice C Porter fuel M. D.

(Address) Hampstead, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

460 ✓ 09919

Reg. Diat. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, Institution, or street address where death occurred:
John St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No. John St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Virgie E. Miller

3.(b) Social Security Number

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Charles F. Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 19 - 1877

8. AGE: Years 70 | Months 0 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland, Howard Co.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER — 12. Name Joel C. Harp

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden name Sadie Frushour

MOTHER — 15. Birthplace Maryland

16. Informant Charles F. Miller

Address Manchester, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 16/47 (month) (day) (year)

Cemetery or crematory Meadow Branch

Location Near Westminster, Md.

18. Funeral director J. E. Myers, Jr.

Address Westminster, Md.

19. Nov. 14 1947 Mrs. W. P. S. Demmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1947; 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 1, 1947 to Nov 13 1947 and that I last saw h.. alive on Nov 13, 1947

Immediate cause of death: Primary Carcinoma of Rectum

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jos. E. Myers M.D. M. D. or other

Address Hampstead, Md. Date signed 11/13/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1340

09320

CERTIFICATE OF DEATH

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur W Nagle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of husband or wife: Grace Seaks

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): March 29-1897

8. AGE:

Years	Months	Days	If less than one day
50	7	12	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Merchant.

11. Industry or business: General Mdse.

FATHER — 12. Name: Frederick Nagle

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Laura Bell.

15. Birthplace: Maryland

16. Informant: Mrs Arthur W Nagle

Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 13 47 (month) (day) (year)

Cemetery or crematory: Sweetmount

Location: Carroll Co Md

18. Funeral director: Edw C Tipton

Address: Hampstead Md

19. Nov 12 1947 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11 1947 at 2:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 45 to Nov. 11 1947 and that I last saw h. alive on Nov. 11 1947

Immediate cause of death	DURATION
Cerebral Edema	10 min.
Due to: Acute Cardiac Dilitation	15 min.
Due to: Hypertensive Cardio Vascular disease	5 yrs
Other conditions: Nephro-lithiasis (left) (Include pregnancy within 3 months of death)	10 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Maurice C. Carter Jr. M. D.

Address: Hampstead, Md Date signed 11-12-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09921

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 2 Mons., 2 Days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 145 W. West Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ELAINE NEWMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 20, 1936

8. AGE:

Years	Months	Days	If less than one day
11	0	10	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER
12. Name: Isaac Newman
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bessie Johnson
15. Birthplace: Unknown

16. Informant: Miss. Estelle Newman (Aunt.)
Address: 145 W. West St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/47 (month) (day) (year)

Cemetery or crematory: Mt Calvary 12/3/47

Location: A. A. County

16. Funeral director: Isaac L. Freeman & Son

Address: 10 & W mont gomery st

19. Nov. 30, 1947 (Date rec'd by registrar) Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 1947, at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28, 1947, to Nov. 30, 1947 and that I last saw her alive on November 30, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Freeman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 11-30-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

159 09922

MARYLAND STATE DEPARTMENT OF HEALTH + Death

CERTIFICATE OF ~~STILL~~BIRTH

Reg. Dist. No. 71

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

Child lived 12 minutes to 1 hr only mistaken as 3rd stage of labor

1. PLACE OF BIRTH:

County Carroll

City or town Rural-Uniontown
(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution: Union Bridge R. #1

Length of mother's stay in County 6 years
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland

County Cardoll

City or town Rural-Uniontown
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. Union Bridge
(If RURAL give LOCATION)

3. Name of child Baby Null

4. Date of birth Nov. 24 1947 Hour 12 30 P. M.

5. Sex male | 6. Twin or triplet

7. No. of weeks pregnancy 18 weeks

FATHER OF CHILD

8. Full name William Jennings Null

9. Color W 10. Age at time of this birth 50 yrs.

11. Usual occupation Laborer

MOTHER OF CHILD

12. Full maiden name Veanie Odell Hutton

13. Color W 14. Age at time of this birth 43 yrs.

15. Usual occupation Housework

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 4

(b) How many other children were born alive but are now dead? none (c) How many other children were *born* dead? none

17. Did child die before labor? no During labor? no Just after

18. Pregnancy, complications of Fever probably salpingitis

19. Labor: (a) Complications of none

(b) Induced? no

20. (a) Was there an operation for delivery? no
(Yes or No)

(b) State all operations, if any none

(c) Did child die before operation? —

During operation? —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity

(b) Maternal causes Probable salpingeas Mother is frail & has lost her eighth

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature E. Reese Wilkens
(Specify if M. D., midwife, or other)

Address Westminster, Md.

23. (a) burial (b) Date thereof Nov. 24, 1947
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Family burying ground

24. (a) Funeral director none but child's father

(b) Address R. D. Union Bridge

25. (a) Nov. 24 '47 (b) Margaret R. Engl
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

.....Health Officer, per.....

V. S. A10

* See Instruction C on stub.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09923

97

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years, 4 months, 27 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 29 years, 4 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1392 W. North Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie Porter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William Porter
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 11, 1868

8. AGE: Years	Months	Days	If less than one day
79	2	4	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Adolph Richter
13. Birthplace: Germany
MOTHER 14. Maiden name: Mary Piek
15. Birthplace: Germany
16. Informant: Hospital records
Address: Springfield State Hospital
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 18 1947 (month) (day) (year)
Cemetery or crematory: Baltimore Cemetery
Location: Balto. Md.
18. Funeral director: Wm. Cook, Inc.
Address: 1217 St. Paul St.
19. Nov 16 1947 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15, 1947, at 5.30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to November 15, 1947
and that I last saw her alive on November 15, 1947

Immediate cause of death	DURATION
Gangrene of left hand and fore - arm	3 days
Due to arteriosclerosis about	12 years
Due to	
Other conditions Schizophrenia, paranoid type	30 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene H. Hekman, M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 11-15-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09924

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years, 5 mos. 2 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 27 years 5 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unk.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Rabich

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Unk -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1882 ?

8. AGE:	Years	Months	Days	If less than one day
	65	?	?	hrs. min.

9. Birthplace: Alsace (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: Unk.
13. Birthplace:

MOTHER
14. Maiden name: Unk.
15. Birthplace:

16. Informant: Springfield State Hospital records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1947 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cemetery
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. Nov 15 1947 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 1947, at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2 1947, to November 14 1947
and that I last saw him alive on November 14 1947

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to:	
Due to:	
Other conditions: Dementia praecox	27 yrs.
arteriosclerosis	12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Martin Gross, M.D.
Martin Gross, M.D. or other
Address: Springfield St. Hosp. Date signed: 11/14/47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

09925

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Wakefield near New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Wakefield near New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Eugene Reese

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 4, 1868

8. AGE: Years	Months	Days	If less than one day
79	10	12	..... hrs. ..... min.

9. Birthplace: Westminster, Md. (Town, county, and state)
10. Usual occupation: store clerk (retired)
11. Industry or business

FATHER
12. Name: William Reese
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Jane Yingling
15. Birthplace: Maryland

16. Informant: William D. Reese
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/18/47 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 11/17 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16 19 47, at 8½ a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 19 47, to Nov 16 19 47
and that I last saw him alive on Nov. 15 19 47

Immediate cause of death	DURATION
Acute Cardiac Dilatation	12 hrs.
Due to: Chronic Interstitial Nephritis	5 yrs.
Due to: Arterio Sclerosis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas R Fouty MD M. D. or other
Address: Westminster Md Date signed 11-17-47

09926

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107 BC

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years, 5 months, 22 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 29 years, 5 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2118 West Fairmont Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (a) FULL NAME Nora C. Richardson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Samuel Richardson

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): January 5th, 1883. ?

8. AGE: Years ~~64~~ 64 | Months 10 | Days 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: .....

FATHER — 12. Name: George Pfeiffer; 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Margaret Shipley; 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/15/47 (month) (day) (year)

Cemetery or crematory: Mt Olivet Cem

Location: Frederick Rd.

18. Funeral director: Edward Loudon

Address: 2339 Wash. Blvd.

19. 11-14 1947 (Date rec'd by registrar) A. W. Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1947, at 4.50a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942, to November 12, 1947 and that I last saw h...er alive on November 12, 1947

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Due to:	.....
Due to:	.....
Other conditions: Schizophrenia, hebephrenic type	about 34 years

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Irene Hickman, M. D. M. D. or other

Address: Springfield State Hosp. Date signed 11-13-47

1-5-83

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09927

CERTIFICATE OF DEATH

Reg. Diat. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Preston Marshall Rinehart

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of ~~husband~~ or wife Minnie B. Rinehart

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27-1873

8. AGE: Years 73 | Months | Days | If less than one day hrs. min.

9. Birthplace Frederick County, Md

(Town, county, and state)

10. Usual occupation machinist

11. Industry or business Retired

FATHER 12. Name Winfield S. Rinehart

13. Birthplace Maryland

MOTHER 14. Maiden name Minnie M. Hewelbiss

15. Birthplace Maryland

16. Informant David R Rinehart

Address Union Bridge, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 23-1947 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Uniontown Road

18. Funeral director D D Hartzler & Sons

Address Union Bridge & New Windsor, Md

19. Nov 22, 1947 (Date rec'd by registrar) Leslie L Pfoff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 19 47 at 1:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 19 47 to Nov 21 19 47

and that I last saw h~~im~~er alive on Nov 20 19 47

Immediate cause of death Chronic Myocarditis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Union Bridge Date signed 11-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09928

186a

CERTIFICATE OF DEATH

Reg. Diat. No. 70

1. PLACE OF DEATH:
County: Carroll Co
City or town: Near Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Month
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ella Roden Roden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife: Walter Roden
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 4 1867

8. AGE: Years 77 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Frederick Gunther
13. Birthplace: Harford Co Md

MOTHER
14. Maiden name: Elizabeth Hartsman
15. Birthplace: Scranton Pa.

16. Informant: Geo R Roden
Address: 334 S Lehigh Ave Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 21-47 (month) (day) (year)
Cemetery or crematory: Orems Cemetery
Location: Sleimes Run Rd.

18. Funeral director: Raymond F Wright
Address: Union Bridge Md.

19. Nov. 19 19 47 Mary B. Witt Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 6 1947 to Nov. 18 1947
and that I last saw h.e alive on Nov. 18 1947

Immediate cause of death	DURATION
Hypostatic Pneumonia	4 days
Due to: Fracture of right femur from a fall at home	21 days
Due to:	
Other conditions: Right hemiplegia, Chronic Arteritis, Chronic Myocarditis (include pregnancy within 3 months of death)	

Major findings of operations: None Done Date of op.
Autopsy results: None done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10/29/47
Where did injury occur? Taneytown (City or town) Carroll (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Fell on bathroom floor Injured at work? No

23. SIGNATURE: R. S. McVaugh M.D.
M. D. or other
Address: Taneytown, Md. Date signed: Nov. 18, 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The full name and age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 6932

Reg. Dist. No. 94

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? March 6, 1912

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 45 years 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County ~~Carroll~~

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. Unk —
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Peter Rodofsky

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

8.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1877 ?

8. AGE: Years	Months	Days	If less than one day
70	?	?	....hrs. ....min.

9. Birthplace Russia
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER
12. Name Joseph Rodofsky
13. Birthplace Russia

MOTHER
14. Maiden name Unk
15. Birthplace Russia

18. Informant Springfield State Hospital
Address records

17. Burial Date thereof 11-19-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Cross Cem.

Location Balto. Md.

18. Funeral director Joseph Kasinskas

Address 662 Washington Blvd.

19. Nov 17 1947 C. Harry Eckel
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1947 at 5:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947, to November 17, 1947 and that I last saw him alive on Nov 17 1947

Immediate cause of death	DURATION
Multiple carbuncles	1 week
arteriosclerosis, chronic myocarditis	
Due to	14 years
Due to	
Other conditions Chronic alcoholic hallucinosis	35 years

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results pyelonephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Martin Gross, M.D.
M. D. or other

Address Springfield State Hospital Date signed 11/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940 09930

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: (Carroll)
County ~~Montgomery~~ Frederick Md
City or town Mount Pleasant Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
Lawnwell
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ~~Md~~ Md (Carroll) County ~~Frederick~~ (Frederick Md)
City or town Frankslng - Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. ~~Frederick Md~~ Lawnwell
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella Rose Rupp

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Emory Rupp
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6th, 1883

8. AGE: Years 64 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Md Frederick
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Louis Lecompte
13. Birthplace Md

MOTHER
14. Maiden name Eleanor Ross
15. Birthplace Md

16. Informant Emory Rupp
Address Frankslburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 12th 1947 (month) (day) (year)
Cemetery or crematory Mt Western Lem
Location Frederick Road Balto Md

18. Funeral director Leo G. Lesnick
Address 1701-03 N. Patterson Park Ave

19. NOV 10 1947 (Date rec'd by registrar) Md Clay Eagle Reg. registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Prior to November 10 1947 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death Coronary Artery Disease — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Mead Deputy Medical Examiner
M. D. or other
Address Westminster Md Date signed 11-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d 09931

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:
19 E. Main

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 19 E. Main
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Gust Sarris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Greek	Widowed

6.(b) Name of husband or wife Pauline Sarris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 17 - 1885

8. AGE:

Years	Months	Days	If less than one day
62	3	23	..... hrs. ..... min.

9. Birthplace Dardanelle, Turkey
(Town, county, and state)

10. Usual occupation Chef

11. Industry or business

FATHER
12. Name John Sarris
13. Birthplace Dardanelle, Turkey

MOTHER
14. Maiden name Mary Kulo
15. Birthplace Greece

16. Informant Gust Barber

Address Bond St. Ext. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12-1947 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 11/11 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1947, at 9:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to Nov. 10 1947

and that I last saw h..m alive on Nov. 9 - 47 1947

Immediate cause of death	DURATION
Myocarditis (chr).	
Syphilis (aort)	
Due to	
Due to Hypotension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D.
M. D. or other

Address Westminster, Md. Date signed 11-11-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

134 BC 09932

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Yr., 2 Mons., 15 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore -31-
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1437 E. Fayette Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN HENRY SHAW

3.(b) Social Security Number: 216-05-3014

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 3, 1912

8. AGE: Years	Months	Days	If less than one day
35	2	15	hrs. min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Alec Shaw
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Hanna Mc Keifee
15. Birthplace: South Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/21/47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Brooklyn, Md.

18. Funeral director: Elroy O. Wilson

Address: 1000 B Fayette ave

19. Nov. 18, 19 47 (Date rec'd by registrar) Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18 19 47 at 7:20P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3, 19 46, to Nov. 18, 19 47 and that I last saw him alive on November 18 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben M. Swan, M.D. M. D. or other

Address: Henryton, Md. Date signed: 11-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09933

138

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 1 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Landover (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ELLA MARTHA SMITH

3.(b) Social Security Number

4. Sex: female
5. Color or race: colored
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) June 28, 1882

8. AGE:	Years	Months	Days	If less than one day
	65	4	23	... hrs. ... min.

9. Birthplace Prince George's Co. Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Frank Smith
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Green
15. Birthplace Maryland

16. Informant Mrs. Hester Brooks
Address Landover, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/24/47 (month) (day) (year)
Cemetery or crematory
Location Woodmore, Md
18. Funeral director Malvan + Schey Inc.
Address 424-R-St. N. W. Wash. D.C.

19. Nov. 20, 1947 (Date rec'd by registrar) Albert R. Swanthan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1947 at 10.00 Am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1947, to Nov., 20 1947 and that I last saw her alive on November 20 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	June 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Md Date signed 11/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09934

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 2 mons., 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bengies, Md. P.O.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY LUVENIA STATEN (Wilson)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 7, 1923

8. AGE: Years	Months	Days	If less than one day
24	0	22	..... hrs. ..... min.

9. Birthplace Middle River, (Balto.) Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name James Staten
13. Birthplace Unknown

MOTHER
14. Maiden name Sarah ?
15. Birthplace Virginia

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal? Which?) Date thereof 12/2/47 (month) (day) (year)
Cemetery or crematory Shank's Ch. Cemetery
Location Chase, Md.

18. Funeral director Mrs. Robert Elliott & daughter
Address 1129 N. Caroline St.

19. Nov. 29, 1947 (Date rec'd by registrar) Albert R. Swarbeck Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1947, at 7:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17, 1945, to Nov. 29, 1947
and that I last saw her alive on November 29, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	March 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben A. Kinsey M.D. M. D. or other
Address Henryton, Md. Date signed 11-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55 ℓ

09935

CERTIFICATE OF DEATH

Reg. Diat. No. 77

1. PLACE OF DEATH:
County Carroll
City or town Hampstead Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Vernon Alexander Stump

3.(b) Social Security Number 213-01-1069

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Mary Loretta Stump
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) June 8, 1893

8. AGE: Years	Months	Days	If less than one day
54	5	21	hrs. min.

9. Birthplace Manchester Md
(Town, county, and state)
10. Usual occupation Automobile Salesman
11. Industry or business Public Chief Safety

FATHER
12. Name John A. Stump
13. Birthplace Manchester Md

MOTHER
14. Maiden name Etta Hanson
15. Birthplace Maryland

16. Informant Mary L. Stump
Address Hampstead Md

17. Burial, cremation, or removal (Which?) Burial Date thereof Dec 2 47 (month) (day) (year)
Cemetery or crematory Greenmount
Location Carroll Co Md

18. Funeral director Edw C Tipton
Address Hampstead Md

19. Dec. 1 1947 John S. Hughes Jr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1947, at 8:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1947, to Nov 29 1947, and that I last saw him alive on November 28 1947

Immediate cause of death	DURATION
Osteogenic Sarcoma Left Femur	7
Due to Pagets Disease of Bone	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Pagets Disease of Bone Date of op. 10-11-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE Joseph E Bunbury M.D.
M. D. or other
Address Hampstead Md Date signed 11-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09936

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 29 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 607 Delaware Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: OTHO TRADER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Tobitha Trader
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): August 15, 1894

8. AGE: Years	Months	Days	If less than one day
53	3	12	....hrs. ....min.

9. Birthplace: Accomac County, Virginia (Town, county, and state)
10. Usual occupation: Canning Factory
11. Industry or business:

FATHER
12. Name: George Trader
13. Birthplace: Accomac County, Va.

MOTHER
14. Maiden name: Ida Justice
15. Birthplace: Accomac County, Va.

16. Informant: Deceased
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11/29/47 (month) (day) (year)
Cemetery or crematory:
Location: Salisbury, Md.
18. Funeral director: J. H. Stewart
Address: Salisbury Md

19. 11-27-47 (Date rec'd by registrar) 19.... Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27, 1947 at 8:00P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29, 1947 to Nov. 27, 1947 and that I last saw him alive on Nov. 27, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 4/23/43
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Nathan Hofman, M. D. (M. D. or other)
Address: Henryton, Md. Date signed: 11-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

09937

CERTIFICATE OF DEATH

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Carroll

City or town: Near Uniontown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Near Uniontown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Cora M. Waltz

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: James S. Waltz

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): October 10, 1868

8. AGE: Years	Months	Days	If less than one day
79	0	27	____ hrs. ____ min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Homes

FATHER
12. Name: John W. Romspert
13. Birthplace: Md.

MOTHER
14. Maiden name: Helan Singer
15. Birthplace: Md.

16. Informant: Mr. Roy E. Waltz
Address: 2421 E. North Avenue, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 9, 1947 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Uniontown, Md.

18. Funeral director: C.O. Fuss & Son

Address: Taneytown, Md.

19. Nov. 9 1947 (Date rec'd by registrar) Margaret R. English Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 6 1947 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1947 to Nov 6 1947 and that I last saw h[illegible] alive on Nov 5. 1947

Immediate cause of death: Coronary occlusion — DURATION

Due to: Diabetes Mel.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: 11-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 1a

09938

Reg. Dist. No. 80

M

1. PLACE OF DEATH: County Carroll; City or town Manchester (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 11 months; Hospital, institution, or street address where death occurred: Long View Nursing Home; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Maryland, County Carroll; City or town New Windsor (If outside city or town limits, write RURAL and give nearest town); Street No. (If rural, give LOCATION); 2.(a) If veteran, name war

3.(a) FULL NAME: George Russell Warner

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife; 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 18 - 1869

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	8	27		

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER 12. Name: Alfred Warner

13. Birthplace: Maryland

MOTHER 14. Maiden name: Elizabeth Myers

15. Birthplace: Maryland

16. Informant: G. Richie Warner

Address: Waynesboro, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 17 - 1947 (month) (day) (year)

Cemetery or crematory: Winters Cemetery

Location: Carroll County, Md.

18. Funeral director: H. H. Hartle & Sons

Address: Union Bridge & New Windsor, Md

19. Nov 15 1947 (Date rec'd by registrar) Emma L. Bunder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 1947 at 1.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 - 1947 to Nov. 14 - 1947 and that I last saw h[illegible] alive on Nov. 13 - 1947

Immediate cause of death	DURATION
Gastric Hemorrhage -	2 hrs.
Due to Left Hemiplegia,	10½ mo
Due to Chronic Interstitial Nephritis -	5 yrs
Due to Arteriosclerosis	6 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations; Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide; Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury; Injured at work?

23. SIGNATURE: Chas R Fouty MD (M. D. or other)

Address: Westminster Md. Date signed 11-14-47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I